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Assessing Health Care Reform: Potential Effects on Insurance Coverage Among Persons With Disabilities

John Gettens[1], Alexis D. Henry[1], and Jay Himmelstein[1]

Abstract

The changes enacted by the Patient Protection and Affordable Care Act are designed to substantially increase health insurance coverage. The authors analyze the health care reforms to assess the potential for increased insurance coverage among persons with disabilities. They estimate that approximately 2 million persons with disabilities will be newly insured; however, they also find a probable unintended consequence of the health care reforms: that some persons with disabilities will lose their current Medicaid coverage. The article outlines policy changes that would prevent this unintended consequence before full implementation of the changes in 2014.

Keywords

health care, medicare/medicaid, policy, eligibility

The changes enacted by the Patient Protection and Affordable Care Act (PPACA) are designed to substantially increase health insurance coverage for all Americans by filling gaps in the existing system of public and private coverage. In this article, we analyze the PPACA changes to assess the potential for increased insurance coverage among working-age (19–64) persons with disabilities. The PPACA changes are extensive and we do not analyze all provisions but rather focus on the Title I—Quality, Affordable Health Care for All Americans—and Title II—Role of Public Programs—provisions that we expect will affect insurance coverage among persons with disabilities. This analysis is based on the health care reform provisions in place as of the time of this writing (May 2011).

We assess the PPACA effects on persons with disabilities as a separate subgroup because we expect persons with disabilities to be affected differently than persons without disabilities. Compared with persons without disabilities, persons with disabilities have lower employment rates and higher participation in public health insurance. Only approximately two out of five working-age persons with disabilities are employed, and consequently employer sponsored insurance (ESI) can play only a relatively minor role in achieving increased insurance coverage among persons with disabilities.[1] If substantial increases are to be achieved, it must be mainly through increases in private (non-ESI) or public coverage.

On average, persons with disabilities have a higher need for medical services and less income compared with persons without disabilities. Stapleton and Liu (2009) estimate that the annual national per-capita health care expenditure for working-age persons with disabilities is more than 4 times the expenditure for persons without disabilities. The poverty rate among persons with disabilities is more than double the rate among persons without disabilities (29.2% vs. 12.2%; see Note 1). The combination of high medical need and low income make insurance coverage a critical necessity for many persons with disabilities. More than two thirds of uninsured persons with disabilities do not have a regular doctor and nearly two thirds have serious problems paying for physician visits or prescription drugs (Hanson, Neuman, Dutwin, & Kasper, 2003).

As we discuss in detail below, PPACA provides new subsidized (non-ESI) insurance opportunities and our analysis suggests that many currently uninsured persons with disabilities will gain insurance through these opportunities. However, we find the new insurance opportunities will also

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Table 1. Characteristics of Noncategorical Medicaid, Exchange Plans, and Medicaid for Persons With Severe Disabilities

Characteristic	Noncategorical Medicaid	Subsidized exchange plans	Medicaid for persons with disabilities
Income limit	133% FPL	400% FPL	Varies across states from a minimum of the SSI program income limit (range of 76% to 158% of FPL) to no income limit[a]
Income methodology	IRS tax rules (modified adjusted gross income)	IRS tax rules (modified adjusted gross income)	SSI program income methodology with some variation within state eligibility groups and across states
Member premiums	Not allowed	Sliding scale ranging from 4% to 9.5% of income	Not allowed for persons with income of less than 150% FPL
Member copayments	Up to 10% of service costs, annual cost capped at 5% of family income	Varies by family income, ranges from approximately US$4,000 to US$8,000 per year[b]	Up to 10% of service costs, annual cost capped at 5% of family income
Coverage requirements	Benchmark coverage[c]	Essential health benefits[d]	Federally mandated and state optional services[e]
Disability requirement	No	No	Yes
Federal share of benefit subsidy	90% for persons who are newly eligible[f]	100%	Varies across states from 50% to approximately 75%

Note: FPL = federal poverty level; SSI = supplemental security income; IRS = Internal Revenue Service.
[a]Massachusetts does not have an income limit but does require premium payments for persons with income above 150% FPL.
[b]The amounts reflect 2010 circumstances.
[c]See text for a description of benchmark coverage.
[d]See text for a description of essential health benefits.
[e]See A. Sommers, Ghosh, & Rousseau, 2005.
[f]The newly eligible are persons who are not otherwise eligible for the state's Medicaid program under the state's eligibility rules that existed as of December 1, 2009.

change the financial incentives for states currently providing optional, expanded Medicaid eligibility. In the past, states had a financial incentive to expand Medicaid eligibility to increase federal revenue. PPACA reverses the incentive; under the PPACA changes, there will be an incentive for states to increase federal revenue by reducing Medicaid eligibility. As a result, we expect that some persons with severe disabilities will lose Medicaid coverage and consequently will lose needed medical services and incur higher out-of-pocket costs.

New Health Care Reform Insurance Opportunities

The PPACA provides new subsidized insurance opportunities for persons with income of less than 400% of the federal poverty level (FPL). Because 9 out of every 10 uninsured persons with disabilities have income of less than 400% FPL, we focus our analysis on these new opportunities (see Note 1). In the following paragraphs, we describe the characteristics of the new opportunities and when applicable, compare the characteristics of the new opportunities with the current Medicaid program for persons with disabilities (Table 1). To simplify the discussion, we describe the characteristics that are predominant in Medicaid. In actuality, Medicaid for persons with severe disabilities consists of many eligibility groups with varying characteristics. Bruen, Wiener, and Thomas (2003) provide a detailed description of mandatory and optional eligibility groups for persons with disabilities.

Noncategorical Medicaid

There are two new subsidized insurance opportunities. The first is a new Medicaid eligibility group, "noncategorical" Medicaid, available to persons with income below 133% FPL (Social Security Act Amendments [SSA], 2010a).[2] Eligibility for noncategorical Medicaid is not dependent on a person's disability status. This is different from existing Medicaid where most working-age Medicaid participants with disabilities qualify for Medicaid because of their disability. Eligibility for current disability-based Medicaid requires that a person have a severe disability. To meet the disability criteria, a person must be unable to earn at substantial levels because of a physical or mental impairment that is expected to last at least 12 months (SSA, 2010b). Many working-age persons with disabilities do not meet the criteria for severe disability because of earnings capacity or

disability duration and therefore do not currently have access to Medicaid. Noncategorical Medicaid will change this, providing an opportunity for Medicaid coverage without regard to disability status.

PPACA specifies an important subgroup of noncategorical Medicaid participants, referred to as the *newly eligible*. The newly eligible are noncategorical Medicaid participants who are not otherwise eligible for the state's Medicaid program under the eligibility rules that existed as of December 1, 2009 (SSA, 2010a). We use this meaning of newly eligible for the remainder of this article. The federal government will cover 90% of the costs for the newly eligible, which is much greater than the federal share for other Medicaid participants; this disparity will change financial incentives for state Medicaid expansions. We discuss the consequences of this disparity below.

In addition to providing a new Medicaid opportunity for persons who do not meet the criteria for severe disability, the 133% FPL income limit of noncategorical Medicaid will extend Medicaid eligibility to higher total (earned and unearned) income levels for persons who have income in excess of the current Medicaid income limits. Some persons with income levels higher than 133% FPL currently have Medicaid eligibility, mainly by virtue of living in states with expansive Medicaid programs but many do not.

The 133% of FPL income limit of noncategorical Medicaid is the program characteristic frequently cited to describe the financial extent of the Medicaid expansion; however, the income limit alone does not provide a complete description. A complete description requires two characteristics: the income limit and income methodology. The income methodology comprises the rules for what income to count, how much income from a particular source to count, whose income to count, and when to count it. Using the respective program income methodology for a given family's circumstances, including family composition, income, and in some cases expenses, an adjusted income can be determined. The adjusted income can then be compared with the program income limit to determine financial eligibility. The income methodology and income limit, in combination, describe the extent of financial eligibility for a program.

The income methodology for noncategorical Medicaid adopts Internal Revenue Service (IRS) tax rules to arrive at the taxpayer's modified adjusted gross income (MAGI). The MAGI is the amount on the last line of the front page of Federal Tax Form 1040, plus tax exempt interest. We refer to this methodology as the MAGI methodology. The income methodology for disability-based Medicaid is based on the income methodology of the Supplemental Security Income (SSI) program (SSI income methodology) and is very different from the MAGI income methodology. A complete description of differences between the MAGI and SSI income methodologies is beyond the scope of this article. Angeles (2011) describes differences between the MAGI methodology and preexisting Medicaid methodologies. It is important to the discussion below to emphasize that, for a given family, the adjusted income amount determined using the MAGI income methodology will not equal the adjusted income amount determined using the SSI income methodology. Paradoxically, because of the differences in income methodologies, for some family circumstances, the preexisting Medicaid may be more financially expansive compared with noncategorical Medicaid, even though the preexisting Medicaid income limit (as percentage of FPL) is more restrictive. We discuss this in more detail below.

We do not expect cost to be a barrier to noncategorical Medicaid participation because noncategorical Medicaid will be either no cost or low cost for participants. Current Medicaid rules do not allow states to charge premiums to persons with income below 150% FPL; however, copayments are allowed (Coughlin & Zuckerman, 2008). Prior to the Deficit Reduction Act of 2005 (DRA), copayments were limited to nominal amounts, generally US$3 or less per service. The DRA-authorized states to impose higher copayments, up to 10% of service costs, with the total annual cost capped at 5% of family income (Medicaid Program, 2010a). To date, no states have implemented the higher DRA-authorized cost sharing and none appear to have immediate plans to do so (Smith, Gifford, Ellis, Rudowitz, & Snyder, 2010).

Whether the coverage provided by noncategorical Medicaid will be as comprehensive as full Medicaid is uncertain. Noncategorical Medicaid participants will receive "benchmark" coverage (PPACA, 2010a). Benchmark coverage, authorized by the DRA, gives states the flexibility to provide nonstandard coverage to subgroups of Medicaid recipients. States may implement benchmark coverage to either increase or decrease services relative to the standard Medicaid state coverage (Medicaid Program, 2010b). Of concern to persons with disabilities is the fact that benchmark coverage for noncategorical Medicaid could potentially be less comprehensive than full Medicaid coverage. However, it appears that the coverage of at least some persons with disabilities will be protected. The DRA specifies that some persons are exempt from mandatory enrollment in benchmark coverage and must be given the option of full Medicaid benefits. This includes persons who are medically frail or who have special medical needs. Federal regulations issued April 30, 2010, authorize states to define the exemption, with the requirement that state definitions at least include "individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living" (Medicaid Program, 2010b). Given this requirement, we expect that many persons with disabilities

will meet these criteria and be exempt from mandatory benchmark coverage. For this expectation to be realized, states must establish effective processes to determine the exemptions.

Although benchmark coverage was originally authorized by the DRA to give states the flexibility to provide benefits other than the standard state Medicaid coverage to subgroups, benchmark coverage for noncategorical members could conceivably be identical to standard state Medicaid coverage. For states that elect to provide identical coverage, their administrative burden will be lessened. These states will not have the administrative costs of determining exemptions from benchmark coverage. Because the benchmark coverage and standard Medicaid coverage would be identical, determining exemption status would not be necessary.

States and the federal government share the costs of Medicaid. The federal share is known as the federal medical assistance percentage (FMAP). The FMAP is based on the state per capita income relative to the national per capita income and ranges from 50% to approximately 75% (Baumrucker, 2010). PPACA specifies a higher FMAP, 90%, for noncategorical Medicaid members who are newly eligible. A noncategorical Medicaid participant is newly eligible if he or she would not otherwise be eligible for the state's Medicaid program under the eligibility rules that existed as of December 1, 2009 (SSA, 2010a). The FMAP for noncategorical members who are not newly eligible will be the state percentage for pre-PPACA Medicaid.

Subsidized Exchange Plans

PPACA also provides a new subsidized private insurance opportunity for low- and moderate-income persons. The subsidy is provided through federal tax credits for persons with income up to 400% FPL who purchase private insurance through the PPACA-mandated state insurance Exchanges. The federal government will be responsible for the full costs of the tax credits and unlike Medicaid states will not share a portion of the subsidy costs. The MAGI income methodology will also be used to determine subsidies for Exchange-based plans. Persons will only be eligible for tax credits for the months when they are not otherwise eligible for "minimum essential coverage" through Medicaid, Medicare, or ESI (Internal Revenue Code [IRC], 2010). The premiums (net tax credit) for Exchange-based plans will vary depending on family income and size. For example, in 2010 dollars, the premiums (net tax credit) for Exchange plans will be approximately US$110 per month for a family of four at 150% FPL and US$524 per month for a family of four at 300% FPL. These amounts correspond to 4% and 9.5% of income, respectively. Premiums cannot vary based on medical conditions, and coverage cannot be denied because of preexisting conditions.

Cost sharing (deductible and copayment) amounts will also be reduced for low- and moderate-income persons (PPACA, 2010b). Using the 2010 out-of-pocket limits for family coverage as an example, the maximum out-of-pocket costs of US$11,900 would be reduced by two thirds to US$3,967 for family income between 100% and 200% FPL, by one half to US$5,950 for family income between 200% and 300% FPL, and by one third to US$7,933 for family income between 300% and 400% FPL (Chaikind, Fernandez, Newsom, & Peterson, 2010).

Insurance available through the Exchanges must meet the PPACA criteria of "essential health benefits." The scope of services required to meet the essential health benefits criteria are only minimally specified in the PPACA. However, the PPACA does specify that essential health benefits include mental health and substance-use disorder services, rehabilitative and habilitative services and devices, preventive and wellness services, and chronic disease management (PPACA, 2010c). The scope of services under the Exchange plans must be comparable with the typical employer plan (PPACA, 2010c). In addition, the Public Health Services Act provisions mandating parity between mental health/substance abuse disorder benefits and medical and surgical benefits will also apply to plans purchased through the Exchanges (PPACA, 2010d).

Potential for Increased Insurance Coverage

Will the PPACA increase the insurance coverage among persons with disabilities? We look to the outcomes of the Massachusetts reforms, implemented in 2006 and 2007, for experience-based information. The policies of the Massachusetts reforms are not identical to the national reforms; however, the similarities are sufficient to use the Massachusetts experience to demonstrate the potential. Similar to the national reforms, the Massachusetts reforms provide coverage, without premiums, to low-income persons. In Massachusetts, the income limit for no-premium coverage is 150% FPL, a limit that is comparable with the national reform limit of 133% FPL. The Massachusetts income methodology is different from the MAGI income methodology. In the Massachusetts methodology, all income is summed to determine a gross income without the adjustments included in the MAGI methodology. Because of the adjustments of the MAGI methodology, the actual effective difference in income eligibility between Massachusetts and the federal reforms is smaller than is evident in the direct comparison of income limits. The income eligibility for premium subsidies is also comparable between Massachusetts and the federal reforms. The Massachusetts reforms provide premium subsidies for persons with income up to 300% FPL compared with up to 400% FPL for the national reforms.

For those who receive premium subsidies, the premium costs (net subsidy) under the national reform will be comparable with Massachusetts. For example, in 2010 dollars, the subsidized premium costs for a plan in Massachusetts for a family of four with income of 200% FPL is approximately US$200 per month, compared with an estimated US$232 under the national reform.

The outcomes of the Massachusetts reforms demonstrate that a substantial increase in the number of persons insured is very much possible. Prior research has demonstrated that the Massachusetts reforms reduced uninsurance among working-age persons by approximately half (Long, Stockley, & Yemane, 2009). Separate estimates for the subgroup of working-age persons with disabilities also show reductions in uninsurance of approximately half, from 11.2% prior to the reforms to 5.4% in the 2 years the following reforms, with the insurance gains occurring within the Massachusetts subsidized insurance programs (Gettens, Mitra, Henry, & Himmelstein, in press). Because of the policy similarities, the outcomes of the Massachusetts reforms demonstrate the potential for the national reforms. Assuming a national reduction in uninsurance among working-age persons with disabilities comparable with the Massachusetts reduction, approximately one half, the uninsurance rate would fall from 19.9% (3.8 million persons) to 9.9% (1.9 million persons; see Note 1). Nearly 2 million persons with disabilities would gain insurance. Because Massachusetts prereform rates were already much lower compared with current national uninsurance rates (excluding Massachusetts), the potential exists for an even greater percentage of reduction nationally.

Although the policies are similar between the national reforms and the Massachusetts reforms, policy is not the only determinant of outcomes. Program implementation and operations also affect outcomes. Massachusetts conducted very strong outreach and enrollment activities, including an extensive public education campaign and automatic enrollment of low-income uninsured persons participating in existing state programs. Massachusetts also streamlined the application process, creating a common application for Medicaid and subsidized private insurance. The strong outreach and enrollment and the streamlined application process likely contributed to the Massachusetts success (Dorn, Hill, & Hogan, 2009). The national reform also mandates a streamlined application process. Whether the outreach and enrollment activities will be consistently strong across states under the national reforms is uncertain. States may be reluctant to conduct strong outreach activities because they fear increased state Medicaid costs if the outreach results in increased enrollment of persons who are eligible for preexisting Medicaid (woodwork effect). These persons will be more costly for states compared with the newly eligible because the FMAP for pre-PPACA Medicaid will apply rather than the higher FMAP for newly eligible persons.

An important aspect of a streamlined process will be the processing of persons transitioning from Medicaid to Exchange plans and vice versa because of income fluctuations. B. D. Sommers and Rosenbaum (2011) estimate that half of the persons with income below 200% of the poverty level will experience a transition within a year. Persons transitioning will be vulnerable to periods of uninsurance. B. D. Sommers and Rosenbaum and Seifert, Kirk, and Oakes (2010) describe strategies to minimize the coverage disruptions for persons making transitions. Whether or not states will adopt these strategies is uncertain.

In summary, we estimate there will be approximately 2 million newly insured persons with disabilities. We base this finding the insurance increase achieved in Massachusetts given the similarities between the Massachusetts reforms and the national reforms. There is a caveat: If states do not conduct strong outreach and enrollment activities, the increase in the number of insured may be less than estimated.

Potential Unintended Consequence

The two PPACA insurance opportunities, noncategorical Medicaid and Exchange-based subsidies, not only create the potential for increases in insurance coverage but also the risk that some persons will either lose their Medicaid coverage or experience a reduction in Medicaid services. The Medicaid program requires that states provide a baseline level of eligibility and services, but beyond that states have options. In the past, states have used the Medicaid options to fill coverage and service gaps while pulling in matching federal funds. The available matching federal funds provided an incentive for state Medicaid expansions (Vladeck, 2003). There is no precise national accounting of the optional participants or optional costs, but rough estimates, sufficient for our purposes, are available. Roughly one quarter of persons participating in adult disability-based Medicaid are optional participants and 69% of costs are for optional services and optional participants (A. Sommers, Ghosh, & Rousseau, 2005).

The 90% federal financial participation for newly eligible Medicaid participants and the full federal responsibility for Exchange plan tax credits will affect state financial incentives. States will soon have a financial incentive to reduce optional Medicaid participation and, in effect, transfer people and costs from disability-based Medicaid to the largely federally funded newly eligible Medicaid and Exchange-based subsidies. In this context, transfer refers to persons actually transferred from disability-based Medicaid to new PPACA programs or the enrollment of applicants in the new PPACA programs rather than disability-based Medicaid. Thus, rather than Medicaid expansions being a means to increase federal revenue, the opposite will be true. Reductions in optional Medicaid eligibility will be a means to increase federal revenue.

States will be able to transfer disability-based Medicaid participants (and applicants) to the new PPACA programs either through eligibility reductions or simply by enrolling people in either noncategorical Medicaid or Exchange-based subsidies rather than disability-based Medicaid. The potential to transfer people exists because the income limits of the optional Medicaid programs overlap with the income limits of new PPACA programs, and thus some people will meet the financial eligibility requirements for both disability-based Medicaid and the new PPACA programs. It will be up to the states to decide whether these people will be covered in preexisting optional disability-based Medicaid programs or the new PPACA coverage.

Eligibility rules for mandatory and optional Medicaid groups are complex and a complete description of the overlapping financial eligibility is beyond the scope of this article. We refer readers to Bruen, Wiener, and Thomas (2003) and Centers for Medicare and Medicaid Services (2001) for detailed descriptions of mandatory and optional eligibility groups. We illustrate the overlap using the simplified case of a hypothetical state. In the hypothetical state, there are three Medicaid eligibility groups, a mandatory group (SSI recipients), an optional disability-based group referred to as the poverty-level group (persons with income below 100% FPL), and the new PPACA-authorized group, noncategorical Medicaid. The SSI income methodology is used to determine eligibility for the SSI-recipient and poverty-level Medicaid groups and the MAGI income methodology is used for noncategorical Medicaid.

Figure 1 shows the eligibility regions, for a single individual, for these three eligibility groups in two dimensions of income, earned and unearned. For example, if the point representing a person's earned and unearned income amounts falls within region OBA, he or she is eligible for SSI-recipient Medicaid. Correspondingly, a person is eligible for poverty-level Medicaid if his or her income is within the ABDC region. Figure 1 shows the substantial overlap of financial eligibility between the optional poverty-level Medicaid and the new PPACA-authorized noncategorical Medicaid. Persons with income in region AGHC are financially eligible for both poverty-level Medicaid and noncategorical Medicaid. If states eliminate poverty-level Medicaid, persons in this region would be financially eligible for noncategorical Medicaid. Poverty-level Medicaid–eligible persons with income in region GBDH are not financially eligible for noncategorical Medicaid; however, these persons would be financially eligible for Exchange-based subsidies (not shown in diagram). Thus, there is complete overlap in financial eligibility between the optional poverty-level Medicaid program and the new PPACA programs.

The extent to which states can transfer disability-based Medicaid participants to noncategorical Medicaid is limited by PPACA. States will not be able to use noncategorical Medicaid to cover persons who are eligible for *mandatory* disability-based Medicaid groups (mainly persons who receive SSI) or to cover persons who meet the state medical criteria for long-term care (LTC) services (SSA, 2010a). This eliminates much of the potential for costs transfers. Medicaid costs for SSI recipients and LTC services account for a very high percentage, approximately 86% of costs for adult disability-based Medicaid (A. Sommers et al., 2005).

To further restrict the transfer of costs, PPACA specifies that the higher FMAP, 90%, only applies to the newly eligible; that is, the noncategorical Medicaid participants who are not otherwise eligible for the state's Medicaid program under the eligibility rules that existed as of December 1, 2009 (SSA, 2010a). On the surface, this provision would appear to prevent states from benefiting financially by transferring persons from disability-based Medicaid to noncategorical Medicaid; however, the effectiveness of the provision is doubtful for persons with disabilities.

The effectiveness is doubtful because determining whether or not a person with disabilities would be eligible under the former rules is not straightforward. For persons with disabilities, determining eligibility under former rules requires a disability determination. The disability determination is a lengthy and costly process that assesses whether a person is unable to earn at substantial levels because of disability. In the absence of a disability determination, a person's eligibility under the former rules for disability-based Medicaid cannot be known. The disability determination will not be necessary to determine eligibility for noncategorical Medicaid, and states may forgo disability determinations. This is particularly likely for new applicants (starting in 2014) who have not had a prior disability determination. If states forgo disability determinations, eligibility under the former rules will not be known.

Potential Loss of Medicaid Services

If persons are, in effect, transferred from optional Medicaid programs to noncategorical Medicaid, there will be no harm to participants if the covered services are the same. As described above, noncategorical Medicaid participants will receive benchmark coverage which, at state option, could be less comprehensive than full Medicaid coverage. However, persons who are medically frail or who have special medical needs will be exempt from mandatory benchmark coverage and be given the option of full Medicaid benefits. Thus, it is very much possible that many persons with severe disabilities will be exempt from mandatory benchmark coverage and receive full Medicaid benefits. Persons receiving full Medicaid benefits would not be harmed. To ensure that transferred persons are not harmed, states must implement effective processes to determine exemptions.

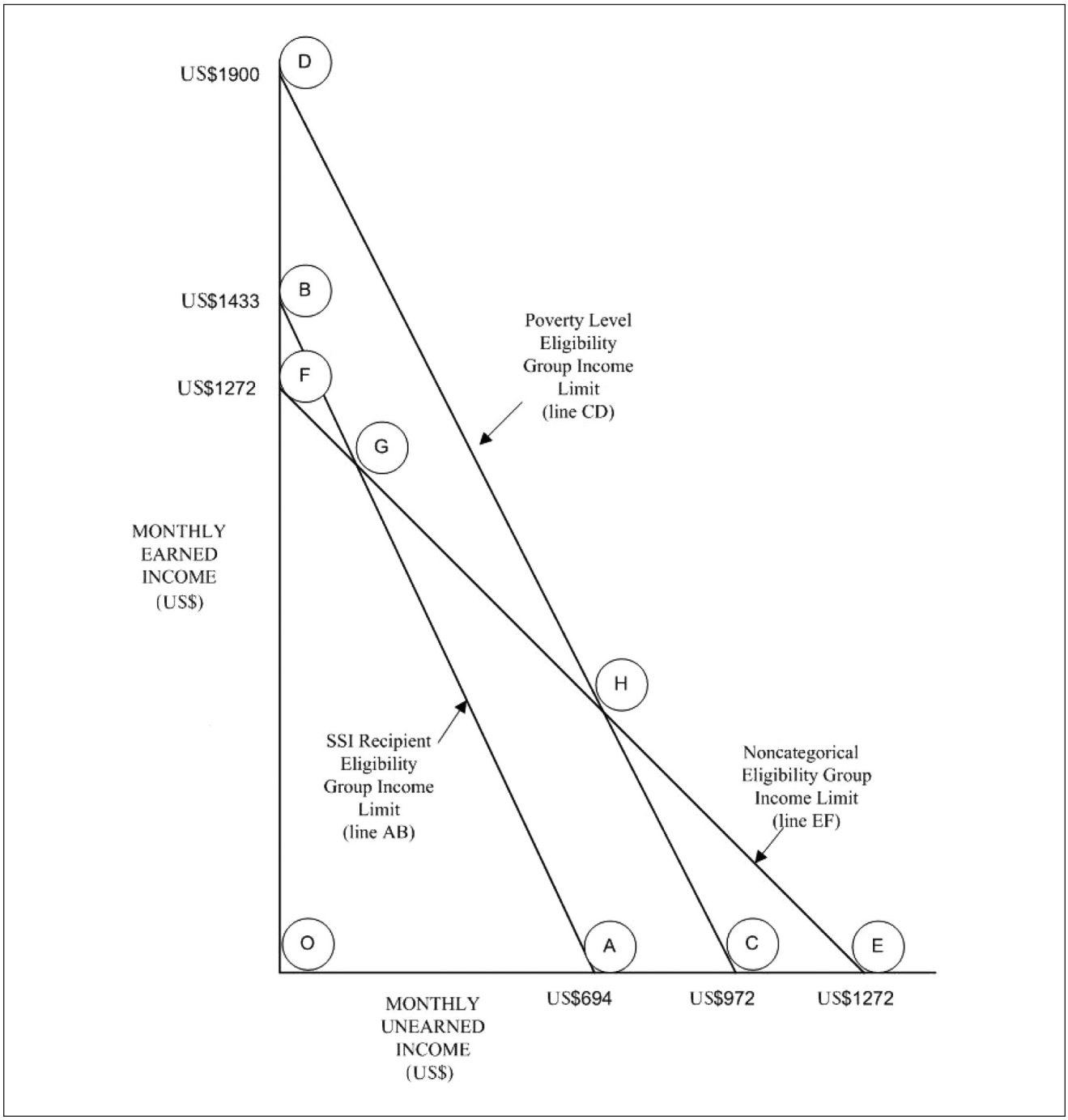

Figure 1. Medicaid eligibility regions for three Medicaid eligibility groups
Note: SSI = supplemental security income. Eligibility regions are depicted in the dimensions of earned and unearned income for SSI-recipient Medicaid, poverty-level Medicaid, and noncategorical Medicaid. The amounts and income limits reflect 2011 poverty levels and SSI program limits. The diagram assumes earned and unearned income types that are not excluded from either the SSI income methodology or the modified adjusted gross income methodology.

Potential Loss of Medicaid Coverage

If exemptions from benchmark coverage are effectively determined and persons are not harmed by a transfer from disability-based Medicaid to noncategorical Medicaid, will there be a problem? There will be a problem if states do the transfer by reducing Medicaid eligibility. The problem exists because some participants in optional disability-based Medicaid programs will be excluded from noncategorical

Table 2. States' Ability to Transfer Persons From Medicaid to New Health Care Reform Programs

Transfer to:	Persons eligible in a mandatory Medicaid group	Persons eligible in an optional Medicaid group	
		Medicare beneficiaries	Others
Transfer to noncategorical medicaid?	No transfer allowed	No transfer allowed[a]	Yes, if person's income less than 133% of federal poverty level[b]
Transfer to subsidized exchange plan?	No transfer allowed	No transfer allowed[a]	Yes if person's income between 133% and 400% of federal poverty level[c]

Note: Shaded table cells indicate circumstances where persons would lose Medicaid if states reduce Medicaid eligibility.
[a]If states reduce Medicaid eligibility, affected Medicare beneficiaries who lose Medicaid will not be able to replace coverage with noncategorical Medicaid or Exchange-based coverage.
[b]The effective income limit is 138% of the federal poverty level because 5% age points of income, relative to the federal poverty level, is deducted (SSA, 2010a). If states reduce Medicaid eligibility, affected persons with income less than 133% of the federal poverty level will be eligible for noncategorical Medicaid and either receive benchmark coverage or be exempt from benchmark coverage and receive full Medicaid benefits. See text for a description of benchmark coverage.
[c]If states reduce Medicaid eligibility, affected persons with income between 133% and 400% of the federal poverty level may be eligible for subsidies for Exchange-based plans; however, costs will be higher and services will be less comprehensive compared with Medicaid.

Medicaid. These persons will lose Medicaid coverage in the event that states reduce eligibility. This is the case for Medicare beneficiaries (Table 2). Medicare beneficiaries will not be eligible for noncategorical Medicaid (PPACA, 2010a).

To estimate an approximate number of Medicare beneficiaries who could lose Medicaid coverage and their associated costs, we use 2008 data from the Medicaid Statistical Information System (MSIS). Medicare beneficiaries were counted as members of optional disability-based Medicaid eligibility groups if they met the following conditions: (a) did not receive LTC services, (b) received Medicaid services on the basis of disability, (c) were not eligible for Medicaid based on receipt of cash assistance, (d) were not eligible on the basis of being medically needy if residing in one of the 11 states with eligibility rules more restrictive than the SSI program (209b states), and (e) participated in the Medicare Saving Program (Qualified Medicare Beneficiaries or Specified Low-Income Medicare Beneficiaries). To determine costs, we calculated the Medicaid service costs minus the costs of services for Home- and Community-Based Care waivers, Nursing Facility, Home Health Care, Mental Health Facility or Intermediate Care facilities for the Mentally Retarded. Because Massachusetts had extensive health care reform Medicaid waivers in effect in 2008, we excluded Massachusetts from the estimate.

Using this definition, we estimate there were approximately 400,000 Medicare beneficiaries in 2008 who participated in optional disability-based Medicaid, receiving approximately US$2.2 billion in services. Medicare beneficiaries who lose Medicaid eligibility will not be able to offset the Medicaid loss with Exchange-based coverage because Medicare beneficiaries are also excluded from Exchange plans (Table 2).

Persons with income above 133% FPL in optional groups would also lose Medicaid coverage (Table 2). This would be true for all optional Medicaid groups but particularly apparent for Medicaid buy-in because Medicare buy-in participants generally have higher income compared with other Medicaid participants. Medicaid buy-in programs provide Medicaid coverage to working persons with disabilities who "buy-in" to Medicaid coverage by paying premiums. The income limits for Medicaid buy-in are higher than most other Medicaid programs, typically up to 250% of FPL. In 2009, there were approximately 154,000 Medicaid buy-in participants in 37 states (Kehn, Croake, & Schimmel, 2010). Using the per member service costs in 2005, the most recent year reported, we estimate that the 154,000 buy-in participants received more than US$2 billion in services (Gimm, Andrews, Schimmel, Ireys, & Liu, 2009). If states eliminate buy-in eligibility, most of the people who lose buy-in eligibility will not be eligible for noncategorical Medicaid either because their income is too high or because they are Medicare beneficiaries. Approximately two thirds of buy-in participants are Medicare beneficiaries. Nonmedicare beneficiaries who lose buy-in eligibility may be eligible for Exchange-based subsidies if they are not eligible for ESI, but coverage will be less comprehensive and costs will be higher. Persons who lose Medicaid services that are necessary for their continued employment, for example personal assistance services, may also lose their jobs.

Unfortunately, data are not available to estimate the total number of persons who would lose Medicaid coverage if states reduce optional Medicaid eligibility. As discussed above, it is possible to estimate the number of Medicare beneficiaries who could lose Medicaid coverage (approximately 400,000). However, there is no data to estimate the number of non-Medicare persons participating in optional

(non-LTC) Medicaid programs who have income greater than 133% FPL (MAGI income methodology) and would not be eligible for noncategorical Medicaid. Using 2008 MSIS data, we estimate there were approximately 250,000 non-Medicare, non-LTC members in optional Medicaid groups. Given the income methodology differences between optional Medicaid and noncategorical Medicaid (Figure 1) and the high income limits of state Medicaid buy-in programs, we expected that a substantial percentage of the approximately 250,000 non-Medicare, non-LTC participants in optional Medicaid programs will have income in excess of noncategorical Medicaid income limit.

In summary, it appears that once the PPACA changes are implemented in 2014, states will face a dilemma. On one hand, it appears that they will be able to reduce Medicaid eligibility to reduce costs while maintaining insurance coverage for some who lose Medicaid coverage, in effect transferring some of the persons affected and their costs to new PPACA coverage. On the other hand, it does not appear that states will be able to do this without harming Medicare beneficiaries who will be excluded from the new coverage or persons who will lose medical services and incur higher out-of-pocket costs in the transfer (mainly persons transferred to Exchange plans).

Whether states will opt to reduce costs through eligibility reductions or maintain existing Medicaid eligibility is uncertain; however, we expect that state fiscal problems will tip the balance toward reducing costs. In recent years, the enhanced FMAP provided by the American Recovery and Reinvestment Act helped states to maintain Medicaid services during the downturn. However, when the enhanced FMAP expires on June 30, 2011, the state share of Medicaid spending is expected to increase by 25% or more (Smith et al., 2010). Unless state revenues recover before 2014, states will be under severe pressure to reduce Medicaid spending at the same time they are implementing health care reform. This will create pressure on states to reduce Medicaid eligibility and expand federal revenue with the rationale that at least some of the people who are cut will be covered under the new PPACA programs.

Policy Options to Address Loss of Medicaid Coverage

The potential loss of Medicaid coverage is an unintended consequence of the PPACA. There are a variety of ways to fix this to ensure that Medicaid participants will not be harmed. We outline four potential solutions. First, the FMAP for optional disability-based Medicaid groups (other than LTC groups) could be increased. This would decrease states' incentives for reducing optional Medicaid eligibility. This would be comparable with the PPACA-increased FMAP for the Children's Health Insurance Program (CHIP). The PPACA increases the CHIP FMAP through Federal Fiscal Year (FFY) 2019 (PPACA, 2010e).

Second, "maintenance of effort" requirements could be extended beyond 2014 for optional disability-based Medicaid groups, an action that would prohibit states from making eligibility cuts. This would be comparable with the PPACA maintenance of effort requirement for state child health plan programs. States are prohibited from reducing eligibility in the State child health plan through September 30, 2019 (PPACA, 2010d).

Third, new optional Medicaid groups could be created to provide states with the flexibility to reduce optional Medicaid eligibility while continuing to provide Medicaid eligibility to persons who would otherwise experience coverage loss. Specifically, an optional group would need to be established for Medicare beneficiaries because Medicare beneficiaries are excluded from noncategorical Medicaid and Exchange plans. In addition, an optional disability-based group would need to be established to provide wrap-around services to Exchange plan participants with disabilities. This would allow persons with income above 133% FPL to obtain their primary coverage through Exchange plans, giving the states the option to provide Medicaid as wrap-around insurance for services not covered in Exchange plans and possibly to also provide premium assistance.

Fourth, stringent federal rules could be implemented to reduce the incentives for Medicaid eligibility reductions by making it more difficult for states to transfer costs to noncategorical Medicaid. For example, federal rules could require disability determinations of noncategorical Medicaid participants who potentially meet the Medicaid disability criteria. This would provide the information necessary to determine whether noncategorical Medicaid participants are eligible under the former Medicaid rules. This would reduce, but not eliminate, cost shifts because there is no flawless way to identify persons who potentially meet the disability criteria.

There are advantages and disadvantages to each of the four solutions. The maintenance of effort requirement maintains the status quo but would reduce the likelihood of any future state Medicaid expansions for persons with disabilities. States expanding Medicaid would face the prospect of assuming new costs that would otherwise be paid by the federal government under the new PPACA programs. The increased FMAP decreases the incentives for state eligibility cuts, with the added advantage of making future expansions less costly for states. The new Medicaid groups also make future Medicaid expansions less costly for states, with an added administrative benefit: They would allow states to cover more people in noncategorical Medicaid rather than disability-based Medicaid, reducing the number of administrative disability determinations. This solution would carry the condition that noncategorical Medicaid

participants who are medically frail or have special health care needs must be identified and given the option to receive full Medicaid benefits. If this was the case, persons who participate in noncategorical Medicaid rather than disability-based Medicaid would not be harmed. The final proposed solution, stringent federal rules, would reduce the financial incentives to transfer persons to noncategorical Medicaid, but it would not affect the incentives for transfer of persons to Exchange-based coverage.

Conclusion

On average, persons with disabilities have higher medical needs and lower income compared with persons without disabilities. The combination of high medical need and low income make health insurance a necessity. We assessed the potential for insurance coverage increases among persons with disabilities under the national health care reforms. We estimate that approximately 2 million persons with disabilities will become newly insured. We base this finding the similarities between the Massachusetts reforms and the national reforms and prior empirical estimates of the effects of the Massachusetts reforms on the insurance of persons with disabilities. There is a caveat, if states do not conduct strong outreach and enrollment activities, the increase in the number of insured may be less than estimated.

It is possible that some Medicaid participants will experience a reduction in services. This could occur among persons with disabilities who receive benchmark coverage rather than full Medicaid benefits. This unintended consequence may be prevented for persons with disabilities if states adopt effective processes to determine exemptions from mandatory benchmark coverage or if states provide benchmark coverage that is identical to full Medicaid coverage.

We also find it likely that some Medicare beneficiaries and persons with disabilities with income above 133% FPL will lose Medicaid coverage once the major PPACA changes are implemented in 2014. The loss of coverage will occur if states reduce Medicaid eligibility to shift costs from the current Medicaid program to the new programs created by PPACA. We do not expect the persons who lose Medicaid coverage will become uninsured but rather they will have less comprehensive coverage and incur higher out-of-pocket costs compared with Medicaid coverage. In the past, states had a financial incentive to expand Medicaid eligibility to increase federal revenue. PPACA reverses the incentive; under the PPACA changes, states will have a financial incentive to reduce Medicaid eligibility to increase federal revenue. State fiscal problems make it likely that at least some states will reduce Medicaid eligibility to shift costs. It is not possible to predict how many states will reduce Medicaid eligibility for persons with disabilities; however, the number of persons who could lose eligibility if states do so is large, more than 400,000 persons. The potential loss of Medicaid coverage is an unintended consequence of the PPACA. We describe solutions that would prevent this unintended consequence.

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Notes

1. Authors' calculation using data from the 2008 American Community Survey. Persons with disabilities are identified using the American Community Survey definition of disability.
2. The effective income limit is 138% FPL because 5% FPL is added to the income limit when determining income eligibility of an individual (Social Security Act Amendments [SSA], 2010a).

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